WELCOME TO OUR OFFICE!

DATE ____/____/_____

HUSBAND OR WIFE'S NAME _____
PARENT'S NAME IF PATIENT IS A MINOR _____
WHOM MAY WE THANK FOR REFERRING YOU _____

PATIENT INFORMATION
PATIENT NAME _____ D.O.B. ___/___/_____ S.S.# _____/_____/_____ SEX M/F
HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL _____
PHYSICIAN'S NAME _____ COLLEGE STUDENT? (COLLEGE) _____

RESPONSIBLE PARTY
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____
HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL _____
D.O.B. ___/___/_____ S.S.# _____/_____/_____ SEX M/F

PRIMARY INSURANCE INFORMATION
INSURANCE COMPANY NAME _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
INSURANCE PHONE _____ GROUP # _____ ID # _____
NAME OF EMPLOYER _____

SECONDARY INSURANCE INFORMATION
INSURANCE COMPANY NAME _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
INSURANCE PHONE _____ GROUP # _____ ID # _____
NAME OF EMPLOYER _____

PATIENTS WITH INSURANCE

I hereby authorize payment from my insurance carrier to be made to this office for the amount due for unpaid itemized dental services. I also authorize the release of any information or records pertaining to me.

_____
SIGNATURE ON FILE

FOR OFFICE USE ONLY
BLOOD PRESSSURE: ___/___/___ _____: ___/___/___ _____: ___/___/___ _____: ___/___/___ _____:
Date BP ___/___/___ _____: ___/___/___ _____: ___/___/___ _____:

HEALTH HISTORY UPDATE: ___/___/___: ___/___/___: ___/___/___: ___/___/___: ___/___/___: ___/___/___:
___/___/___: ___/___/___: ___/___/___: ___/___/___: ___/___/___: ___/___/___: ___/___/___: ___/___/___:

Our office is dedicated to providing you with the highest standards of health care. An essential part of our approach is a thorough health history. Please fill out the health questionnaire completely.

What is your primary concern today? _____

Do you have, or have you had, any of the following? (Circle "Yes" or "No" for each question)

A. Hypoglycemia, Diabetes	Yes No	O. Stroke	Yes No
B. Heart Attack or Heart Trouble	Yes No	P. Heart Murmur	Yes No
C. Hay Fever, Asthma, Allergies	Yes No	Q. Rheumatic Fever	Yes No
D. High Blood Pressure	Yes No	R. Anemia, Blood Disorders	Yes No
E. Circulatory Problems	Yes No	S. Excessive Bleeding	Yes No
F. Hepatitis, Jaundice	Yes No	T. Fainting, Blackouts	Yes No
G. Lung Problems, Tuberculosis	Yes No	U. Nervous Disorders	Yes No
H. Epilepsy, Seizures	Yes No	V. Headaches, Migraines	Yes No
I. Blood Transfusions	Yes No	W. Kidney Problems	Yes No
J. Facial or Head Injuries	Yes No	X. Glaucoma, Eye Troubles	Yes No
K. Radiation Treatments	Yes No	Y. Ulcers, Digestive Problems	Yes No
L. Malignancies, Cancer	Yes No	Z. Are You Pregnant Now?	Yes No
M. Do You Smoke	Yes No	ZZ. AIDS	Yes No
N. Sinus Problems	Yes No	Other: _____	

Have you seen a physician or been hospitalized in the last two years? Yes No
If yes, please give reasons and dates:_____
_____

Have you had any unfavorable reaction to the following?

A. Aspirin	Yes No	D. Anesthetics, Novocain	Yes No
B. Codeine	Yes No	E. Penicillin or Other Antibiotics	Yes No
C. Sedatives, Tranquilizers	Yes No	F. Other Drugs	Yes No

G. Do You Have any Known Metal Allergies (if so what)? _____

List any drugs currently being taken: _____

Have you noticed any of the following?

A. Teeth Tender to Chew On	Yes No	F. Recurring Sores in or Around Mouth	Yes No
B. Discomfort In Face Head or Neck	Yes No	G. Jaw Clicking or Popping	Yes No
C. Food Caught Between Teeth	Yes No	H. Teeth Ache to Hot or Cold	Yes No
D. Bleeding or Sore Gums	Yes No	I. Swelling or Lumps in Mouth	Yes No

The information above is correct to the best of my knowledge. I give my consent to have the necessary treatment recommended for my benefit (or my minor) after it has been discussed and mutually approved.

Patient's Signature (Parent's if patient is a minor) _____